GENERAL COMMENTS

	From Whom?	Subject	Refers to Specific Text	Comments/Recommendations
	External Advisory Team	Overall comment on plan	General response	Overall this is a great plan having only five areas of focus and not complicated. It embodies and is consistent with the vision.
	Dr. Marsha Hammond	Public comments	General response	It would be useful for consumers and providers to be able to see, online, the feedback you are receiving. Can you please make this happen or give me a reason why it cannot?
	Martha Brock, PAIMI Advisory Council Coordinator	Positive aspects of state strategic plan	General response	I appreciate the opportunity to provide comments on the Draft State Plan 2007-2010. I strongly support improvements in the system which can increase the emphasis on client centered, community focused, and fiscally responsible management of the provision. There is much in the draft I found commendable. I won't try to list all of the commendable items, but I do want to express my appreciation for the focus on Comprehensive Crisis Services and Housing in the listing of Action steps and Milestones. In order to achieve community focused services, these must be high priority items in terms of planning and funding.
	Joseph Kilsheimer, Durham CFAC	Overall comment on plan	General response	Several members of the Durham CFAC have reviewed this draft plan and offer the following comments. Overall SSP 2007-2010 is a detailed, thoughtful, ambitious plan We CFAC Members fervently hope that the theories outlined in this plan mesh with the realities of providing such services for the benefit of all consumer of the disability groups.
	Linda Harrington, Director, Division of Vocational Rehabilitation Services	General comments about plan	Chapter 1	On behalf of the Division of Vocational Rehabilitation Services, I appreciate the opportunity to provide feedback on the draft Mental Health State Strategic Plan: 2007-2010. [In closing] I want to emphasize that the Division of Vocational Rehabilitation Services is clearly your partner in this undertaking. We intend to work with your Division to assure that all consumers with the desire to work have the opportunity to achieve their employment goals, whether the goal is traditional employment, supported employment, or self-employment.
	Sally Cameron, NC Psychological Association	General comment on MH reform	General response	The North Carolina Psychological Association appreciates the opportunity to review and comment on the Draft State Strategic Plan 2007-2010. The vision of an efficient, effective public mental-health system remains critical. We agree with the values and guiding principles of the state plan and support the idea of strategic objectives and action steps. We hope that the following comments will be helpful as you move forward with the monumental task of mental health reform.

GENERAL COMMENTS

	From Whom?	Subject	Refers to Specific Text	Comments/Recommendations
	Sally Cameron, NC Psychological Association	General comment on plan	Chapter 1	Throughout the draft, there are references to the role of the Division in providing policy guidance, developing and implementing (strategies, rules, policies, standards, tools, processes, etc.), and other actions to promote consistency and accountability. There is a risk of these roles being enacted through a 'top-down' process. We would suggest that language be added that emphasizes the importance of communication, collaboration, partnership, and meaningful dialogue between all levels of the system. We also suggest that action steps be more specific. Language such as "work with LMEs" and "encourage" do not state clearly what will be done. The lack of adequate funding continues to be one of our major concerns.
	Debra Dihoff, NAMI	Overall comment on plan	General response	Thank you for the opportunity to comment on the draft State Mental Health Plan. I am writing on behalf of the National Alliance on Mental Health (NAMI) North Carolina, which is the largest grass roots advocacy organization representing individuals and their families affected by brain disorders. Our organization has grave concerns regarding the progress of reform. As you may know, NC received a Grade of D plus in the 06 national Grading the State initiative. Many of the recommendations in that report are still very valid, and are integrated into my general responses. The following are some general comments on reform and what we believe we should do immediately to make an impact that will help so many people who are in crisis because of reform.
				1. Stop senseless change that causes disruption to the system: allow the system time to right itself, freeze rate changes and new rules that add layers of bureaucracy.
				2. Restore the public safety net: Realign diagnostic assessment to LME to link with STR and to allow real choice; restore functions to LME like setting uniform fees since the customer will now be going to the LME to be screened, and assessed; LMEs to provide crisis services (may choose to contract); LMEs to provide case management; and case support.
				3. Simplify Earning Money: eliminate waiver requirements before LMEs may provide safety net services; declare an emergency and eliminate IPRS – study simplification; allocate state psychiatric hospital monies to LMEs to purchase necessary crisis and inpatient services locally; revisit target population definitions to simplify earnings; look at ancient fiscal rules and update radically; have one UR system, not a dual system, one for MCAID (Medicaid) and one for state dollars; study actual effectiveness of Value Options and reconsider this strategy; eliminate authorization requirements for less expensive services up to 30 visits, etc.; stop the barriers to getting service and earning the money.
				4. Open up and share information on billings, claims so the system can be managed.

GENERAL COMMENTS

	From Whom?	Subject	Refers to Specific Text	Comments/Recommendations
	Debra Dihoff, NAMI	Continued		5. Get more money into the system: move up from our 43rd per capita funding spot and our D in Grading the States; add money to housing, family education, peer education, job development and training, and state services in general; determine where best practice services are not available, and fund them in locations that are lacking these essential services. Fill the gaps.
				6. Halt closure of state psychiatric beds until crisis services and developed, and effective in reducing admission rates.
				7. Require that positive outcomes be achieved through new service definitions; if not, alter the definitions or try another way.
				8. Get ahead of the curve in decriminalization of those with brain disorders: fund police training (CIT) statewide; using NAMI North Carolina to coordinate over the next two years; begin process of restoring benefits post incarceration; four year plan to implement drug courts and mental health courts statewide; and implement telephonic triage support in jails.
				9. Set up a group to recommend, within 3 months, changes to red tape and bureaucracy and rules that make it unnecessarily difficult to deliver services, addressing all aspects of mental health. Serving on this group should be a provider representative, an LME representative, an advocacy representative, a consumer, and a family member. Division staff should be available to assist in their work.
				Obviously some hard and good work has gone into the development of this plan. Thank you again for the opportunity to share the thoughts of NAMI North Carolina. I know that we all want things to improve for the families and individuals affected by mental illness in North Carolina.
	LOC, Co-chairs Sen. Martin Nesbitt and Rep. Verla Insko	General comments on plan	General response	As the co-chairs of the LOC, we wanted to respond to the draft State Plan ("Draft Plan") that has been prepared by the Department. Overall, the draft Plan is responsive to the requests made by the General Assembly. It is well written and cohesive. We see it as a very positive start to the strategic planning process and hope the Department will continue to do business in this manner. We would also like to share with you some of our thoughts, concerns and suggestions.
				As we mentioned before, it is obvious that a great deal of effort and thought went into the development of this Draft Plan and we find many positive aspects in this product. Our comments and suggestions are not intended to diminish that assessment and we hope that these thoughts will be strongly considered as the Department works to develop the final State Plan.

GENERAL COMMENTS

	From Whom?	Subject	Refers to Specific Text	Comments/Recommendations
	Holly Riddle, NCCDD	Overall comments about plan	General response	On behalf of the NC Council on Developmental Disabilities (NCCDD), thank you for the opportunity to comment on the Draft State Strategic Plan, 2007-2010, for the Division of MH/DD/SAS (DMH/DD/SAS). Generally, the NCCDD commends the DMH/DD/SAS for the manner in which it has addressed measurable outcomes for consumers and the system itself. The action steps and milestones are ambitious. Like other DD advocacy groups, we hope to see the DMH/DD/SAS move away from efforts to frame DD policy and practice in a "recovery model." Minimally, the use of this language is misleading and adds to the public's confusion in distinguishing mental illness from developmental disabilities, as reflected in the "Vision" and "Mission". We do appreciate that you have paired "self-determination" with "recovery" in most places in the document. In this vein, we would encourage you, throughout this document, to reference the reform as MH/DD/SAS reform, rather than "mental health reform" (cf. p.7). NCCDD recommends that the DMH/DD/SAS address downsizing of the developmental centers more directly, in light of the recent announcement of the "Money Follows the Person" CMS grant award. Finally, NCCDD notes the absence of action steps or milestones relative to the DD waiver, CAP-MR/DD. While the plan is cross-disability in nature, continued quality improvement efforts relative to the waiver (e.g., participant direction, supports waiver, etc.) are essential to quality of life for many people with DD. We look forward to collaborating with you over the next three years to support your efforts. The NCCDD looks forward to featuring current and future collaborative efforts with DMH/DD/SAS on the Division's website.
	Judy Dempsey, family member, Albemarle CFAC, SCFAC	General comment on mental health reform	Chapter 1	Before I begin commenting on the Plan, I feel it is important to pass on to you comments made at a Board meeting of my LME and at a staff meeting attended by my husband at the Dare County Mental Health Center. First, it seems to be the conclusion that Mental Health in this state is in a gigantic mess and all the problems being experienced are due to Mental Health Reform.
			General response	Secondly, from the viewpoint of the staffers at the local center, they are expressing frustration with the myriad number of forms they are responsible for completing. The issue of confidentiality is a barrier to some substance abuse consumers who are not showing up for treatment (in one case for an entire year), and the therapist is unable to inform the family which thinks the consumer is getting help. Additionally, 100-day turnaround for payment discourages private providers who need payment in a timely manner so they can pay their own bills. These are concerns need to be addressed before LMEs and their staff are asked to change even more to accommodate the new State Plan.

GENERAL COMMENTS

	From Whom?	Subject	Refers to Specific Text	Comments/Recommendations
	Judy Dempsey, family member, Albemarle CFAC, SCFAC	Vision statement	Introduction, pages iii	In reviewing the Vision Statement, it is hoped that a spirit of cooperation are be developed between the policymakers, the LMES and private providers.
		General comment about plan	General response	In closing I wish to say much thought and work has gone into this document. Hopefully all involved will do their part to provide the intended service to the consumer.

Chapter 1. Introduction, Progress of Reform, Values & Principles

	From Whom?	Subject	Refers to Specific Text	Comments/Recommendations	Division Response:
	Martha Brock, PAIMI Advisory Council Coordinator	Terminology used in plan	Chapter 1, page 5, reference to Guiding Principles	My reading of the draft plan led to some basic questions in the terminology chosen for this document. Previous versions of state plans have focused on the need for "consumer driven" practices. The new plan used the term "participant driven". I question just who a "participant" is and why this term was chosen.	"Participant" includes all consumers of services and supports as well as participants in prevention programs. This terminology is used at the federal level by the Centers for Medicare and Medicaid and National Core Indicators. The Division's guiding principles were revised in November 2005 at a DHHS retreat, at which time "participant-driven" was selected as a guiding principle.
				Also, in the section on Guiding Principles, one of those mentioned is that the system should be "recovery outcome oriented." This is vague and subject to wide interpretation. I support an emphasis on the recovery versus a medical model, but is that what this means?	The President's New Freedom Commission 2003 report recognized recovery as the common outcome for mental health services. That report defines recovery as referring "...*to the process in which people are able to live, work, learn, and participate fully in their communities. For some individuals, recovery is the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or complete remission of symptoms*." Recovery has also been adopted by SAMHSA as a significant outcome for substance abuse services.
	Betsy MacMichael, First in Families	word choice	Chapter 1, page 5	P.5, Line 6 - "live, work and enjoy leisure activities" not play, play is too specific to children	Correction made.
				Line 7 relationship**s** - should be plural	Correction made.

Chapter 1. Introduction, Progress of Reform, Values & Principles

	From Whom?	Subject	Refers to Specific Text	Comments/Recommendations	Division Response:
	Joseph Kilsheimer, Durham CFAC	Information on services	Chapter 1, page 3-4	With, generally, little experience by many CFAC members overall details of service details are sketchy. All services are now being contracted and monitoring by the Division/LMEs should have higher priority and emphasis. one page 3, for example, the document refers to "implemented provider endorsement process for Medicaid." If this refers to Value Options it would seem that little monitoring of the process is occurring.	LMEs are responsible for endorsing providers before they are enrolled with the Division of Medical Assistance and become eligible to provide services. This is a different process from monitoring. See the first objective on the provider system, Action Step 3 regarding monitoring.
				Further appearance of the low value the Division has placed on any monitoring is on page 4. This refers to "Reduce licensure reviews from 1054 to 635." If this refers only to new provides, what is being done to increase adequate facilities required for deinstutionalization (supposedly a goal of the entire reform process).	Actually, the number of licensed providers of child/adolescent residential facilities was reduced to 635 in SFY 2005 as a result of active monitoring by the DHHS divisions of facility services and MH/DD/SAS that found that many did not meet requirements.
		Comment on Guiding Principles	Chapter 1, page 5	On page 5 there is a reference to Guiding Principles - overall up to now this has not been evident in reality.	A list of the Guiding Principles has been included in every State Plan and Annual Report.
	Judy Dempsey, family member, Albemarle CFAC, SCFAC	Uninsured consumers	Chapter 1	At present, there seems to be frustration, anger and an unwillingness by the private providers to become involved with what they view as a failing system of care. Thus those consumers who have no health insurance must rely on the LMES to be their safety net for service.	Thank you for recognizing some of the major challenges in achieving system reform.
		25 accomplishments	Chapter 1, pages 2-4	On viewing the 25 achievements listed, #19 is in question in my catchments area (Albemarle area), as it is a rural area and resort area, where there are not enough qualified providers and providers who are willing to get involved with a system they perceive as broken: therefore the LME must provide for those consumers unable to access the private system.	Thank you for recognizing some of the major challenges in achieving system reform.

Chapter 1. Introduction, Progress of Reform, Values & Principles

	From Whom?	Subject	Refers to Specific Text	Comments/Recommendations	Division Response:
	Holly Riddle, NCCDD	Overall comments about plan	Chapter 1	Generally, the NCCDD commends the DMH/DD/SAS for the manner in which it has addressed measurable outcomes for consumers and the system itself. The action steps and milestones are ambitious. Like other DD advocacy groups, we hope to see the DMH/DD/SAS move away from efforts to frame DD policy and practice in a "recovery model." Minimally, the use of this language is misleading and adds to the public's confusion in distinguishing mental illness from developmental disabilities, as reflected in the "Vision" and "Mission". We do appreciate that you have paired "self-determination" with "recovery" in most places in the document. In this vein, we would encourage you, throughout this document, to reference the reform as MH/DD/SAS reform, rather than "mental health reform" (cf. p.7).	Please note that we have changed the guiding principle to read "Recovery and/or Self-Determination Outcome Oriented". In addition, changes have been made in the document to read "reform of the mental health, developmental disabilities and substance abuse services system".
				NCCDD recommends that the DMH/DD/SAS address downsizing of the developmental centers more directly, in light of the recent announcement of the "Money Follows the Person" CMS grant award. Finally, NCCDD notes the absence of action steps or milestones relative to the DD waiver, CAP-MR/DD.	The Division reserves comment on this until we can study the implications of the grant.
	Holly Riddle, NCCDD	Overall comments about plan	Chapter 1	While the plan is cross-disability in nature, continued quality improvement efforts relative to the waiver (e.g., participant direction, supports waiver, etc.) are essential to quality of life for many people with DD. We look forward to collaborating with you over the next three years to support your efforts.	The five objectives focus on the entire system and cross all disabilities. Each disability area will be addressed in detail in the implementation plan as appropriate.
		Timeframe for 25 accomplishments	Chapter 1, pages 2-4	p. 2 Table 1: Time frame for accomplishments is not clear: 2001-2006?	Yes. The title of the table has been changed to include 2001-2006.

Chapter 1. Introduction, Progress of Reform, Values & Principles

	From Whom?	Subject	Refers to Specific Text	Comments/Recommendations	Division Response:
	Holly Riddle, NCCDD	Comments on 25 accomplishments, Table 1	Chapter 1, pages 2-4	p. 2-4; Table 1, #1: Include numbers/percentages afforded expanded access and more services. #2: Best and evidence-based DD services not addressed; omission? #3: Not clear in what manner the waiver "lays the foundation to move to self-directed services." Suggest you clarify or omit.	Please see additional details regarding accomplishments that were drawn from two documents shown on the Division's web page: http://www.ncdhhs.gov/mhddsas/stateplanimplementation/index.htm. Click on documents named: (1) Milestones and Accomplishments and (2) Tasks and Outcomes.
				#12: Are the "82 beds" more than the 4% downsize mandate we have been working with for years? #14: Not clear whether the assessment of those in developmental centers/psych hospitals is on-going or one-time; timeframe helpful here. #19: Clarify by number/% "most local management entities"	
		Transformed DD System	Chapter 1, page 5	p. 5 Transformed DD system: You may want to consider the cross-walk of the National Core Indicators (NCI) for DD and the CMS HCBS Quality Framework as a way of thinking about outcomes, relative to conveying a vision of a "transformed" DD system. The focus areas and outcomes are listed below, for your convenience, and can be found online at www.hsri.org . We applaud your inclusion of direct support staff and workforce development strategies as an action step (p. 13, Chapter 3 on provider system).	Actually, the Division has based its Quality Management Plan on the National Core Indicators and the federal Centers for Medicare and Medicaid (CMS) Home and Community Based Services (HCBS) Quality Framework. Please see the Division's Quality Management Plan as shown in Chapter 5 of State Plan 2005. Also see the Division's statistical and quality reports as shown on the web page: http://www.ncdhhs.gov/mhddsas/statspublications/reports/index.htm.
				Crosswalk of NCI and CMS Quality Framework Focus Areas and Outcomes:	
				Focus I: Participant Access; Desired Outcome: Individuals have access to home and community-based services and supports in their communities.	

Chapter 1. Introduction, Progress of Reform, Values & Principles

	From Whom?	Subject	Refers to Specific Text	Comments/Recommendations	Division Response:
	Holly Riddle, NCCDD			Focus II: Participant-Centered Service Planning and Delivery; Desired Outcome: Services and supports are planned and effectively implemented in accordance with each participant's unique needs, expressed preferences and decisions concerning his/her life in the community.	
				Focus III: Provider Capacity and Capabilities; Desired Outcome: There are sufficient…providers and they possess and demonstrate the capability to effectively serve participants.	
				Focus IV: Participant Safeguards; Desired Outcome: Participants are safe and secure in their homes and communities, taking into account their informed and expressed choices.	
		Consumer and family principles, Continued	Chapter 1, page 5	Focus V: Participant Rights and Responsibilities; Desired Outcome: Participants receive support to exercise their rights and in accepting personal responsibilities	See above.
				Focus VI: Participant Outcomes and Satisfaction; Desired Outcome: Participants are satisfied with their services and achieve desired outcomes.	
				Focus VII: System Performance; Desired Outcome: The system supports participants efficiently and effectively and constantly strives to improve quality.	

Chapter 1. Introduction, Progress of Reform, Values & Principles

	From Whom?	Subject	Refers to Specific Text	Comments/Recommendations	Division Response:
			Chapter 1, page 6	p. 6 You may want to consider further developing these consumer/family and system principles. NCCDD applauds the adoption of these principles, particularly underscoring those addressing: consumer/family involvement in planning/management (per Senate Bill 2077); self-direction of services; integration/best use of state facilities with community systems of care; attention to provider involvement; workforce development; cultural competence; and data-driven planning, management and evaluation.	Your comments will be given serious consideration as we develop the detailed implementation plan.
	LOC, Co-chairs Sen. Martin Nesbitt and Rep. Verla Insko	General comments on plan	Chapter 1	The draft Plan appears to view LMEs as essentially extensions of the Department. For purposes of monitoring, guidance, and enforcement, this is accurate. However, we would also like to see the State Plan reflect that LMEs are local partners with the State in the necessary implementation of reform.	The suggestion is duly noted and changes have been made to the plan to reflect the importance of such partnerships.

Chapter 2. Overview: Purpose of the strategic plan & process of development

	From Whom?	Subject	Refers to Specific Text	Comments/Recommendations	Division Response:
	Dr. Jack Dempsey, family member, Albemarle CFAC	Organizational orientation of strategic plan	Chapter 2, overview of the strategic plan	I am submitting these comments as the father of a developmentally disabled child in Dare County and as a member of Albemarle's CFAC. I am also a retired professional person with a relevant career history. I have an earned doctorate from Johns Hopkins' school of public health with joint majors in mental hygiene and maternal and child health; I have work experience at local, state and federal levels, principally in planning and evaluation, which I taught at Johns Hopkins. With such a background, I review a plan to determine whether it is population-based (denominator) with equal attention to true and service prevalence (numerators). On the service system side, I look for estimates of community-based clinical capacity, which minimally involves mapping the service system's sheer numbers of providers and location, FTEs (full time equivalents) and comprehensivity of clinical skills per geographic unit. My examination of the draft plan reveals virtually no explicit attention to this orientation.	Please see the Division's quality reports first developed in SFY 07. These reports are on the Division's web site, including the Community Systems Progress Indicators Report and the Semi-Annual System Performance Report. See: http://www.ncdhhs.gov/mhddsas/statspublications/reports/index.htm
		Mapping the service system county by county	Chapter 2, introduction process of development, page 7	In the mandated process of divestiture, which has already begun, one would hope that the very first step would be mapping the service system county by county (to allow aggregation in several ways) to assess the degree to which the local systems have the capacity to accept the divested cases and new cases. There are two tiers to such an assessment. First, just what is out there? A local capacity that is quantitatively or comprehensively (e.g., spectrum of clinical skills) inadequate obviously must be addressed both before divestiture and continuously afterward. Secondly, and perhaps even more importantly, how much of the total capacity is willing to work with the LME? Reducing the gap between total and "willing" capacity becomes a humongously important objective.	Thank you for recognizing major challenges in achieving system reform. This is a complicated process and has been undertaken during SFY 2006 and SFY 2007.

Chapter 2. Overview: Purpose of the strategic plan & process of development

	From Whom?	Subject	Refers to Specific Text	Comments/Recommendations	Division Response:
	Debra Dihoff, NAMI	Other areas to include in plan	Chapter 2, overview of the strategic plan	1. The plan needs to speak much more to the criminal justice system and include strategies such as prevention (CIT, which is spoken to), jail triage supports, drug and mental health courts, post incarceration benefits.	Thank you for recognizing a significant part of the local development of comprehensive crisis services.
		Other areas to include in plan	Chapter 2, overview of the strategic plan	2. Recently shocking data was released by the Mortality and Morbidity group showing that individuals with severe mental illness live 25 years less, on the average. The plan needs to have strategies that specifically address this problem.	This was not identified as one of the five strategic objectives achievable for 2007-2010.
	Holly Riddle, NCCDD	Reference to recovery for individuals with developmental disabilities	Chapter 2, page 7, overview of the strategic plan	Par. 2: “The strategic plan renews the promise that every consumer will have an opportunity for growth, recovery and self-determination.” This phrase implies a developmental disability is a condition or disease from which one can, or should “recover”.	Changed to "… recovery and/or self-determination."

Chapter 3. Introduction & Relationship of 5 objectives to Long-Range Plan

	From Whom?	Subject	Refers to Specific Text	Comments/Recommendations	Division Response:
	Louise Galloway, LCSW, MH professional	Assisted treatment, Treatment Advocacy Centers (submitted 3 PDF articles on assisted outpatient treatment, anosognosia as a cause of violent behavior in individuals with sever psychiatric disorders, and myths about assisted treatment)	Relates to Chapter 3, Introduction, pages 9-10	Thank you for the opportunity to comment on the State Mental Health Plan. I continue to have very grave concerns about North Carolina's State Mental Health Reform. For now I will identify one critical issue of many that is lacking in the draft plan which is the lack of focus on assisted treatment such as the mental health and substance abuse commitment processes. http://www.wxii12.com/news/13349017/detail.html The web link above will take you to a report on a serious shooting incident in Asheboro, NC this week. According to the family, the shooter is mentally ill and has been at Dorothea Dix Hospital many times. None of us will forget the horrible recent events in Blacksburg, Virginia. NC has an outpatient commitment law which has won recognition and it has been extremely valuable in the past. Prior to state reform, the community mental health centers were responsible for following persons on outpatient commitment. Who is responsible now?	Your comments will be given serious consideration as we develop the detailed implementation plan related to the objective for crisis services and related to care coordination as noted in Action Step 4 of the objective on standardized processes.
				The Draft State Plan focuses on Crisis Services and Recovery interventions. Both are very valuable and important, but the Plan misses a critical phase of service for those persons whose judgment remains impaired after a hospital stay or crisis team visit. http://www.psychlaws.org/default.htm The web link above takes you to the Treatment Advocacy Center which provides substantial information about the interventions to which I refer. I will attach several articles from the Treatment Advocacy Center to the email I send to you with this letter.	

Chapter 3. Introduction & Relationship of 5 objectives to Long-Range Plan

	From Whom?	Subject	Refers to Specific Text	Comments/Recommendations	Division Response:
	Louise Galloway, LCSW, MH professional	Assisted treatment, outpatient commitment, Continued	Chapter 3, Introduction, pages 9-10	As a mental health professional, I have seen how effective assertive treatment strategies can be when a mentally ill person suffers from anosognosia---the inability to be aware of their mental illness. (See Treatment Advocacy Center articles.) ACTT is just one assertive methodology. ACTT is excellent but it is a very expensive service that is quite difficult to staff. ACTT cannot be stretched to cover the huge number of persons in NC needing assertive care. Other, less cumbersome, methods must be in place. In order for either mental health or substance abuse outpatient commitment to function effectively many pieces must be in place: 1) Clear cut responsibility for which organization is following the person on commitment. 2) Organizational philosophy supporting the use of these strategies during the phase of treatment when a person's comprehension and acceptance of their illness is weak. 3) Fail-proof tracking mechanisms----outpatient commitment is a legal process with certain benchmarks. Prior to State Reform requirements ending most of the LME clinical services, Sandhills Center-Randolph Services in Asheboro had a detailed computer based system to ensure that benchmarks (such as MD evaluations and court hearings) were met. Such specificity is crucial. 4) Staff training and supervision to ensure effective staff roles.	Your comments will be given serious consideration as we develop the detailed implementation plan related to the objective for crisis services and related to care coordination as noted in Action Step 4 of the objective on standardized processes.

Chapter 3. Introduction & Relationship of 5 objectives to Long-Range Plan

	From Whom?	Subject	Refers to Specific Text	Comments/Recommendations	Division Response:
	Louise Galloway, LCSW, MH professional	Assisted treatment, outpatient commitment	Chapter 3, Introduction, pages 9-10	5) Assertive Services must be billable. It appears that the Community Support definitions offer private providers little incentive to take on the substantial responsibility for assertive service strategies. A public safety net is needed. 6) Organizations with high staff turnover are not the correct group for assertive strategies because knowing the person with mental illness and having an ongoing relationship with that person makes all the difference. Too many Community Support providers have high turnover. In the past, North Carolina has won recognition for its mental health and substance abuse outpatient commitment laws. These mechanisms and other assertive strategies can be critical components the recovery process for persons with mental illness. The State Plan must make a range of assertive treatment strategies a major priority.	As indicated above, your comments will be given serious consideration as we develop the detailed implementation plan related to the objective for crisis services and related to care coordination as noted in Action Step 4 of the objective on standardized processes.
	Dr. Jack Dempsey, family member, Albemarle CFAC	Population-based plans, prevalence and mapping the service system	Chapter 3, long-range plan Table 2, page 36	For instance, refer to Table 2 on p. 36, focusing on row six, “Population, Prevalence and Treated Prevalence.” Reading horizontally, one is directed to three action steps earlier in the text. None of the three addresses prevalence and the word, population, is used once in a vague way. Additionally, the word, capacity, was used once in the entire plan and “mapping the service system’ is found nowhere nor is a close synonym.	Please see the Division's quality reports first developed in SFY 07. These reports are on the Division's web site, including the Community Systems Progress Indicators Report and the Semi-Annual System Performance Report. See: http://www.ncdhhs.gov/mhddsas/statspublications/reports/index.htm.
				(It is entirely possible that these topics were explicitly considered earlier in the state’s planning process but, if so, those considerations have not survived into this public comment plan. It is recognized that this is an incredibly complex reform process and optimal detail on each and every issue is simply not possible.)	Please note that during the last 9 months, the Division has been mapping the system regarding workforce and providers to be published at a later date.

Chapter 3. Introduction & Relationship of 5 objectives to Long-Range Plan

	From Whom?	Subject	Refers to Specific Text	Comments/Recommendations	Division Response:
	Dr. Jack Dempsey, family member, Albemarle CFAC	Population-based service prevalence rates	Chapter 3, introduction Chapter 3, introduction	That is, extraordinarily high or low condition-specific, population-based service prevalence rates may be symptomatic of LME and/or system malfunctions in a county or sets of counties aggregated by proximity, population size and density, ethnicity, etc. Further investigation may find correctable problems. The department of epidemiology at UNC's school of public health may have some staff familiar with this type of analysis.	Please see the Division's quality reports first developed in SFY 07. These reports are on the Division's web site, including the Community Systems Progress Indicators Report and the Semi-Annual System Performance Report. See: http://www.ncdhhs.gov/mhddsas/statspublications/reports/index.htm.
				A word of caution about unconditional commitment to causes. "Divestiture" is in danger of becoming one more fad that will gradually breed its own unique type of chaos requiring another reform movement in the future—witness the deinstitutionalization and privatization movements. Both of them corrected one set of problems and introduced a new set. Elaboration is available on request. It is suggested here that divestiture is only one reform option and it may not be the only or best one in some types of communities. Putting all of one's reform eggs in one basket may be an absurd form of stupidity.	Thank you for recognizing major challenges in achieving system reform.
		Overall improvement of mental health service system		In closing, I would like to express my admiration for state officials for trying to improve the mental health service system. One only hopes, however, that an inflexible commitment to divestiture as a cure-all in all types of communities doesn't end up throwing the baby out with the bath water.	

Chapter 3. Introduction & Relationship of 5 objectives to Long-Range Plan

	From Whom?	Subject	Refers to Specific Text	Comments/Recommendations	Division Response:
	Martha Brock, PAIMI Advisory Council Coordinator	Comparison of state plan 2004 versus state plan 2007-2010 on timing of changes in transformation	Chapter 3, introduction	I have reviewed the comments on the 2004 Draft State Plan done by the NC Psychological Association. What impresses me most is that although the plans for 2004 and the Plan for 2007-2010 are very different, the NCPA's observations on programmatic issues are still quite valid. I quote: "Given the long list of essential tasks in this category, we cannot emphasize enough how important it is to slow down the process until the details of the plan have been decided, the concerns of stakeholders addressed, and sufficient community capacity has been developed to provide adequate services to target populations." Please slow down, and indeed stop the transformation where necessary, until the stakeholders are onboard for making change and please stop accusing those who criticize the Division's implementation of being merely afraid of change.	Thank you for recognizing major challenges in achieving system reform.
	Debra Dihoff, NAMI	Outpatient services	Chapter 3, introduction	I also agree with the points Louise Galloway made in her May 19 letter. Clear cut responsibility is important on so many levels- not just regarding outpatient commitment. I agree that we must have a larger range of assertive treatment strategies as a major priority. (See Galloway comment above)	Your comments will be given serious consideration as we develop the detailed implementation plan related to the objective for crisis services and related to care coordination as noted in Action Step 4 of the objective on standardized processes.

Objective: Stable and High Quality Provider System

	From Whom?	Subject	Refers to Specific Text	Comments/Recommendations	Division Response:
	Tom Savidge, External Advisory Team	Measurement	p. 38, table 3, provider system	Recommends that the measures specify a specific percentage for achievement.	We acknowledge the importance of this recommendation. Performance targets are often different for each LME. In addition, we have not yet established baselines for all outcomes.
	David Swann, External Advisory Team	Funding	-	Recommends that the Division fund pilot projects to test creative ideas.	We acknowledge the importance of this recommendation. The Division has used RFAs to support development of various service definitions such as mobile crisis.
	Dr. Jack Dempsey, family member, Albemarle CFAC	Provider system capacity	Chapter 3, objective on provider system	From bits and pieces of information I've heard or read about statewide, this gap between willing and total capacity is significant. Some, probably many, private providers perceive the state reform initiative as a mess, inclining them to take at least a wait-and-see attitude about cooperating, if not a total unwillingness to be dragged into it. The "hundred day turnaround" for service reimbursement is seen as a symptom of inefficiency if not a total disregard for the provider's economic needs. They apparently see the extra paperwork as diluting the amount of time they can devote to service. And so on. Reducing the gap requires reducing the disincentives, which deserves to be an objective unto itself.	Please see the Division's quality reports first developed in SFY 07. These reports are on the Division's web site, including the Community Systems Progress Indicators Report and the Semi-Annual System Performance Report. See: http://www.ncdhhs.gov/mhddsas/statspublications/reports/index.htm.
	Dr. Jack Dempsey, family member, Albemarle CFAC	Provider system capacity	Chapter 3, objective on provider system	A word about prevalence. Estimating true prevalence has proved to be such a can of worms that many epidemiologists have recommended by-passing it. (I can cite literature on this if needed.) Instead, they suggest using service utilization rates as a minimum estimate of prevalence. If these rates are constructed uniformly among counties (counties for maximum flexibility in aggregation at regional and state levels), service utilization rates, assuming fairly constant true prevalence among counties, become a useful managerial tool for detecting underserved needs.	Please see the Division's quality reports first developed in SFY 07. These reports are on the Division's web site, including the Community Systems Progress Indicators Report and the Semi-Annual System Performance Report. See: http://www.ncdhhs.gov/mhddsas/statspublications/reports/index.htm.

Objective: Stable and High Quality Provider System

	From Whom?	Subject	Refers to Specific Text	Comments/Recommendations	Division Response:
		Appropriate provider services		That is a conclusion I've reached as a father of a developmentally disabled child served in both a group home and ADAP center in Dare County. Those were stellar programs before divestiture. My daughter was well served and my wife and I were delighted overall with the responsiveness of the staff to our expressed needs. With divestiture, however, a private organization assumed control. They couldn't do so immediately, however, because they couldn't find local staff. Dare County has a severe low-income housing shortage. Even teachers have trouble finding affordable accommodations and there are declining numbers of people in the county who are willing to take low-paying jobs without benefits such as public employees get. Things deteriorated so badly that Albemarle Mental Health withdrew its contract with the firm and contracted with another firm for PART of the operation, retaining part for itself for at least a time. Quality service has returned after a not-so-pleasant experience and has left at least this consumer with a greater sense of trust and security in the public sector for a county with a labor force like this one. Divestiture is not quite a four-letter word here, but it's a cause for concern.	Thank you for recognizing major challenges in achieving system reform.
	SCFAC (submitted by Judy Dempsey, SCFAC representative)	Identifying best practices	Chapter 3, objective 1 on provider system, pages 13-15	Page 12, Action Step 1, Clearly identify what the Best Practices are. Page 13, Action Step 3, Provide the necessary funds to do this. Action Step 5, discontinue rationing of bed days and provide more services for the DD population. Page 15, Use of MH Trust Funds, First bullet: add to the end of the statement, "and System of care", Second bullet: CPAC (Consumer Provider Advisory Committee) are already in place and are presently providing technical assistance.	Your comments will be given serious consideration as we develop the detailed implementation plan related to this objective. .

Objective: Stable and High Quality Provider System

	From Whom?	Subject	Refers to Specific Text	Comments/Recommendations	Division Response:
	Martha Brock, PAIMI Advisory Council Coordinator	Terminology used in plan	Chapter 3, objective 1 on provider system, pages 14 and 16	In a similar vein the discussion in the current draft discusses “individualized planning and supports.” Does this refer specifically to “person-centered plans? If not, why not?	Yes. The statute says "individualized planning and supports". This is the same as person-centered plans.
	Betsy MacMichael, First in Families	misplacement of word(s)	Chapter 3, objective 1, page 10	Chapter 3 - love the objectives! P.14 (actually 10) Line 5 - there are two redundant words- "a" and "for" should be deleted	Correction made.
		Assuring crisis service plans for all consumers	Chapter 3, objective on crisis services	P.18 (actually page 14) - Consumer outcomes, third bullet: change "increase percentage" to "100%"- there should be nothing less at this point in the "transformation"!!	We acknowledge the importance of this recommendation. Performance targets are often different for each LME. In addition, we have not yet established baselines for all outcomes.
	Thea Dockery	Support for providers	Chapter 3, objective on provider system	Provide free counseling for stressed out providers instead of losing their service. Providers need to form parent committees to monitor children's progress. Proper mental health treatment for the uninsured consumers.	Your comments will be given serious consideration as we develop the detailed implementation plan related to this objective.
	Joseph Kilsheimer, Durham CFAC	Comment on provider system	Chapter 3, objective on provider system, page 11	Page 11, The emphasis on "business management" is somewhat of a problem as there is no measure for probity in this area. The reference to trained staff has now been recognized by the Division with the latest bulletin postponing this to 2009. Minimum funding which is being provided by the Legislature discouraged competitive Providers who might have the ability and desire to improve "Quality of Life" for consumers. (We have comments from staff, that even the minimum requirements, i.e. submission of NCTOPPS data is not happening. If this was enforced a host of Providers would be disqualified).	Thank you for recognizing major challenges in achieving system reform.

Objective: Stable and High Quality Provider System

	From Whom?	Subject	Refers to Specific Text	Comments/Recommendations	Division Response:
		Training providers	Chapter 3, objective on provider system, page 12	Page 12 Action Step 3 6/30/09 seems to be a late date to train LMEs to monitor and improve quality of providers.	Your comments will be given serious consideration as we develop the detailed implementation plan related to this objective.
		Monitoring measures of success including consumer outcomes and system performance	Chapter 3, objective on provider system	Page 14 Measures of Success, as listed Consumer Outcomes and System Performance are good as measures. How will these be monitored?	See chapter 4, Measures of Results. Regular monitoring will occur and be communicated via the Division's web site.
	Joseph Kilsheimer, Durham CFAC	Oversight of contract on technical assistance for provider		Page 15 A red flag to some members is "Contract...to provide technical assistance." How is oversight to occur?	Thank you for your comments. The Mental Health Trust Fund will be used in accordance with requirements of the General Assembly.
	Debra Dihoff, NAMI	Evidence-based practices	Chapter 3, objective on provider system	The plan mentions a goal to improve actual accessibility to evidence based practices. We are aware of the systemic loss of evidence-based practice models like psychosocial rehabilitation around the state. Given your stated goal of stabilization of providers, I think we need a count of failed programs, and a genuine attempt to stop the closure of programs- that is the definition of stabilization. Programs may move into a different model, but limiting access through systemic system closures via financial failures must stop. To that end, the plan must address simplification of earning state dollars, and elimination of dual systems.	Your comments will be given serious consideration as we develop the detailed implementation plan related to this objective.
	Judy Dempsey, family member, Albemarle CFAC, SCFAC	Flexibility for the provide workforce	Chapter 3, objective on provider system	The first objective: Establish and support a stable and high Quality Provider System with an adequate number and choice of providers is absolutely essential but in areas where quality providers are limited, there needs to be some flexibility and possibly incentives for areas such as ours where a worker can make more money cleaning houses than working as a staff person at a group home.	Your comments will be given serious consideration as we develop the detailed implementation plan related to this objective.

Objective: Stable and High Quality Provider System

	From Whom?	Subject	Refers to Specific Text	Comments/Recommendations	Division Response:
		Informing and empowering consumers	Chapter 3, objective on provider system, action steps 2 and 3, pages 12-13	Action Step 1, # 2 informing consumers and their families about how to access the system and that the system needs to be responsive to their needs in a timely manner is essential. Action Step 3, Defining provider performance standards are essential but the bottom line is consumer outcome.	Your comments will be given serious consideration as we develop the detailed implementation plan related to this objective.
	Judy Dempsey, family member, Albemarle CFAC, SCFAC	Use of mental health trust funds	Chapter 3, objective on provider system, page 15	The development of consumer friendly materials, providing technical assistance, supporting the development of training curricula and media, funding proposal for the development of evidence-based practices, technical support and assistance are very appropriate uses of this fund.	Thank you for your comments. The Mental Health Trust Fund will be used in accordance with requirements of the General Assembly.
	Holly Riddle, NCCDD	Various comments and changes to text in objective on provider system	Chapter 3, objective on provider system, page 11	Paragraph 1: Compare "desired services…are…evidence–based or best practice" to NCCDD's suggested language: "providers demonstrate the ability to provide services and supports in an effective and efficient manner consistent with the individual's plan." Paragraph 2: A "stable provider system" also means that participants have continuous access to assistance as needed to obtain and coordinate services and promptly address issues encountered in community living. Paragraph 3: discussion of "high quality" service provision: consider noting as an example that significant changes in a person's needs or circumstances promptly trigger consideration of modifications in the person-centered plan. Consider dropping "clinical" at line 5.	Suggested changes made.

Objective: Stable and High Quality Provider System

	From Whom?	Subject	Refers to Specific Text	Comments/Recommendations	Division Response:
	Holly Riddle, NCCDD	Various comments and changes to text in objective on provider system	Chapter 3, objective on provider system, page 11	Paragraph 4: Suggested edit: "Before they achieve full endorsement, agency and individual providers must demonstrate that they possess the requisite skills, competencies and qualifications to support participants effectively." Paragraph 5: Choice also means that consumers and families have the option of choosing, hiring and managing service providers. Without this feature, there is not a truly "competitive market system." Consumers should be more than "informed about choices." They should also have continuous access to assistance. Paragraph 6: The "menu of services" should be flexible enough to respond to consumers and families changing needs. "Appropriate services" would be better replaced with "services and supports consistent with the person-centered plan."	Change made.
			Chapter 3, objective on provider system, page 12-14	p.12-14, Action Steps and Milestones and Measures: Overall, very clear; well done. Page12, Action Step 1: Consider replacing "fulfill their responsibility" with "actively participate".	Edits made.
				p.12, Action Step 2: benefit design should ensure equal access to all services in the state service array across geographic areas p.12, Action Step 2: Revise state plan and state Medicaid plan to include services such as Supported Employment, Respite, and Peer Supports for all populations.	Your comments will be given serious consideration as we develop the detailed implementation plan related to this objective.

Objective: Stable and High Quality Provider System

	From Whom?	Subject	Refers to Specific Text	Comments/Recommendations	Division Response:
	Holly Riddle, NCCDD	Various comments and changes to text in objective on provider system	Chapter 3, objective on provider system, page 12-14	p.13. Action Step 3: Identify tools for LMEs to use in addressing provider accountability and quality, such as incentives and sanctions that can be administered by the LMEs at the local level. p. 13: Action Step 4, Bullet 2: Note that the applicability of workforce development strategies may differ among various service sectors (MH, DD, SA).	Your comments will be given serious consideration as we develop the detailed implementation plan related to this objective.
				p. 13: Action Step 5: Is the DMH/DD/SAS proposing transfers of public ICF-MR to private ICF-MR as a vehicle for downsizing the developmental centers? Would this create additional ICF beds in the state? If so, NCCDD would suggest that this strategy warrants further scrutiny. Consider additional strategies/action steps that would allow movement of ICF dollars to waiver-funded services, such as those demonstrated in the 1915(b)(c) waiver at PBH. (Note: PBH's strategy does not increase the ICF entitlement if restricted to deinstitutionalization.)	This strategy will not create additional ICF-MR beds.
				p. 14: Action Step 5, Bullet 4 (on page): "By 6/30/09, develop and implement policies and protocols that ensure continuity of care between community and State operated facilities." This bullet warrants a separate Action Step with accompanying Milestones.	See Action Step 4 of the objective on standardized processes.
	Sally Cameron, NC Psychological Association	Redefining qualified provider	Chapter 3, objective on provider system	We agree with the goal of a stable and qualified provider system and acknowledge that some services are being provided in greater quantities than are needed. We suggest this is due to non-clinicians making decisions about what consumers need. A revamping of the definitions of qualified provider is needed.	Your comments will be given serious consideration as we develop the detailed implementation plan related to this objective. See Action Step 4 of this objective.
	Sally Cameron, NC Psychological Association	Supported treatments	Chapter 3, objective on provider system, action step 3, page 13	Action step 3: We suggest that expectations include the provision of empirically supported treatments in the community.	Your comments will be given serious consideration as we develop the detailed implementation plan related to this objective. In addition, the work of the Practice Improvement Collaborative (PIC) will be a key here.

Objective: Stable and High Quality Provider System

	From Whom?	Subject	Refers to Specific Text	Comments/Recommendations	Division Response:
		Measures of success for clinical improvement	Chapter 3, objective on provider system, measures of success, page 14	Measures of success: Have clinical outcomes for consumers been considered? Choice, timeliness, and participation are essential. However, clinical improvement should also be measured.	Yes. See chapter 4, Measures of Results.
	LOC, Co-chairs Sen. Martin Nesbitt and Rep. Verla Insko	Expansion of evidence based practices throughout the state	Chapter 3, objective on provider system, pages 11, 14, 15 and 16	Similarly, we would like to see more attention paid to how the State is going to move providers towards actually using evidence based practices.	Your comments will be given serious consideration as we develop the detailed implementation plan related to this objective.
		Expanding workforce development	Chapter 3, objective on provider system	Finally, there needs to be a greater focus on workforce development. There is a lack of clarity regarding who (the State, LMEs, or providers) is responsible for this necessary function. We would urge the Division to explicitly take the lead in that role and thereby clarify responsibilities and expectations.	The Division and the NC Commission for Mental Health, Developmental Disabilities and Substance Abuse Services is in the process of developing strategies for workforce development.

Objective: Comprehensive Crisis Services

	From Whom?	Subject	Refers to Specific Text	Comments/Recommendations	Division Response:
	SCFAC (submitted by Judy Dempsey, SCFAC representative)	Crisis Intervention Training	Chapter 3, objective 2 on crisis services, page 18	Page 18, Action Step 3, Second bullet: add Crisis Intervention Training (CIT).	Your comments will be given serious consideration as we develop the detailed implementation plan related to this objective.
		Measures of success for crisis services	Chapter 3, objective 2 on crisis services, page 19	Page 19, Measures of Success, Last text box: Add "Reduce percentage of incarceration".	
		Use of MH Trust Funds	Chapter 3, objective 2 on crisis services, page 20	Page 20, Use of MH Trust Funds, and there is a need to check the target for use of trust fund dollars.	Thank you for your comments. The Mental Health Trust Fund will be used in accordance with requirements of the General Assembly.
	Martha Brock, PAIMI Advisory Council Coordinator	Divesting programs	Chapter 3, objective 2 on crisis services (and Chapter 5 on Use of MH Funds, page 43-44)	There is a fundamental problem in the Plan in accepting a continued focus on the Local Management Entities (LMEs) divesting programs simply to achieve “privatization” for its own sake, particularly in the area of case management and crisis services. I hope that a change in the plan in this area will be forthcoming, although I realize it will take some time to achieve. I have spoken out on this issue before to Rep. Verla Insko of the Legislative Oversight Committee, and I think we will be seeing some changes legislatively in this area in the future. The loss of the “safety net” previously available to consumers in many area programs has still to be dealt with in many areas of the state. Allowing LME’s to provide direct services where none are available from private providers is a necessity. For the meantime, I hope that a slowing down of the divesture process will give all parities involved an opportunity to review how well the process has worked to date.	Your comments will be given serious consideration as we develop the detailed implementation plan related to this objective.
	Debra Dihoff, NAMI	CIT training	Chapter 3, objective on crisis services	The support for [Crisis Intervention Training] CIT throughout the state is an excellent element of the plan.	Thank you for your comments,

Objective: Comprehensive Crisis Services

	From Whom?	Subject	Refers to Specific Text	Comments/Recommendations	Division Response:
	Judy Dempsey, family member, Albemarle CFAC, SCFAC	Accessing crisis services	Chapter 3, objective on crisis services, pages 17	Action Step 1: It is important to involve consumers and their families so they can access the system.	Your comments will be given serious consideration as we develop the detailed implementation plan related to this objective.
		Training LMEs and providers	Chapter 3, objective on crisis services, pages 18	Action Step 3 & 4: Training of LMEs and their Providers and establishing a cooperative relationship with area hospitals, primary care physicians and others including emergency management are important goals.	
		Measures of success for crisis services	Chapter 3, objective on crisis services, page 19	Both consumer outcomes and system performance are appropriate measure of success but, what about tracking the percentage of consumers who have a crisis plan and were hospitalized at one time but have been able to maintain stability either through natural supports or continuing provider support?	
		Use of MH Trust Funds	Chapter 3, objective on crisis services, page 19	A good use of Mental Health Trust Funds is a one-time start-up funds transition support, short-term support and the development of training materials.	Thank you for your comments. The Mental Health Trust Fund will be used in accordance with requirements of the General Assembly.
	Holly Riddle, NCCDD	Various text changes in crisis services action steps	Chapter 3, objective on crisis services, pages 16-19	Crisis Services-NCCDD would again commend the action steps and takes particular note of the inclusion of action step 5 at p. 19, re: LME authority over admissions to state developmental centers.	Your comments will be given serious consideration as we develop the detailed implementation plan related to this objective.
	Holly Riddle, NCCDD	Various text changes in crisis services action steps	Chapter 3, objective on crisis services, pages 16-19	p. 16: A "fully developed person-centered plan" is described as including "actions to prevent escalation of a crisis." Consider, however, strengthening the language in this paragraph to address the assessment of health risk and safety considerations and identification of potential interventions that promote health, independence and safety, developed with the informed involvement of the participant and family. While you do note "behavioral" supports, access to health services and use of strategies to promote safety are equally critical to avoiding crises for people with DD.	Edits made.

Objective: Comprehensive Crisis Services

	From Whom?	Subject	Refers to Specific Text	Comments/Recommendations	Division Response:
				p. 19: "health and safety plans" may be a more applicable term than "crisis prevention/intervention" for most people with DD and is a term that would address crises proactively. p. 19: develop resources for crisis intervention that include on-site consultation and support. p. 19: develop crisis alternatives for adolescents, including adolescents with developmental disabilities. p. 19: System performance: It is not clear that these measures are as applicable to people with DD as they are to MH and SA populations.	Your comments will be given serious consideration as we develop the detailed implementation plan related to this objective.
	Sally Cameron, NC Psychological Association	General comment on crisis services	Chapter 3, objective on crisis services	The availability of comprehensive crisis services is a vital part of the state's mental health system of care, and was one of the inadequacies of the old system in many areas of the state, so we salute your attention to this area. There needs to be more detail as to how this plan will be implemented (e.g. who is going to do what and how are they going to do it). Given the complexity and difficulties inherent in providing crisis services, reimbursement rates need to be high enough for private agencies to make a profit.	Thank you for recognizing major challenges in achieving system reform.
		Training consumers on crisis services	Chapter 3, objective on crisis services, action step 1, page 17	Action Step 1: Training consumers and family on crisis planning and accessing crisis services (and when not to use crisis services) is important and may result in decreased use of crisis and hospitals.	Your comments will be given serious consideration as we develop the detailed implementation plan related to this objective.
		Crisis services for each age and disability group	Chapter 3, objective on crisis services, action step 2, page 18	Action Step 2: Recognition of different needs for crisis services based on each age and disability group is an important aspirational goal. How will this be accomplished?	

Objective: Comprehensive Crisis Services

	From Whom?	Subject	Refers to Specific Text	Comments/Recommendations	Division Response:
		Cooperation among agencies and facilities for crisis services	Chapter 3, objective on crisis services, action step 4, page 18	Action step 4: Establishing cooperation between hospitals, primary care physicians, clinics and community agencies, is a valuable idea but no one knows how to actually do this and the logistics are overwhelming.	Thank you for recognizing major challenges in achieving system reform.
		LME incentives	Chapter 3, objective on crisis services, action step 5, page 19	Action Step 5: What incentives are being developed for LMEs? If they are financial, LMEs may be vulnerable to a lawsuit.	Your comments will be given serious consideration as we develop the detailed implementation plan related to this objective.
	Sally Cameron, NC Psychological Association	Measures of success for crisis services	Chapter 3, objective on crisis services, measures of success, page 19	Measures of success: We suggest that consumer outcomes also address multiple hospitalizations in a year in addition to re-hospitalization within 30 days of inpatient discharge.	Your comments will be given serious consideration as we develop the detailed implementation plan related to this objective.
		Use of MH Trust Funds	Chapter 3, objective on crisis services, use of MH Trust Fund, page 20	Use of Mental Health Trust Funds: The plan to support a contracting agency until they are self-sufficient is a major concern. Crisis services need to be fully funded, not fee for service. Fee for service is tantamount to paying the fire department by the number of fires they put out.	
	LOC, Co-chairs Sen. Martin Nesbitt and Rep. Verla Insko	Implementing local and regional crisis services	Chapter 3, objective on crisis services	As reflected in recent appropriations, the General Assembly recognizes that adequate crisis services are critical for all citizens. We urge the Department to increase the focus of the State Plan on crisis services, especially on implementing and coordinating local and regional crisis service plans.	Your comments will be given serious consideration as we develop the detailed implementation plan related to this objective.

Objective: Integrated & standardized processes and procedures

	From Whom?	Subject	Refers to Specific Text	Comments/Recommendations	Division Response:
	Dr. Jack Dempsey, family member, Albemarle CFAC	Number of forms required	Chapter 3, objective on standardization	Given that divestiture may be only part of the managerial mix in some counties, another problem needs to be addressed. I met with the staff at one of the mental health clinics still offering public services. One of their many concerns is the sheer volume of forms they have to complete at intake. Indeed, when a troubled family comes in for service, they help fill out forms during the intake interview and don't get to talk much about their problems until the next session. That's an insult to consumers and I assume we have CFAC to point things like that out. While state management requires quality service to consumers, it hasn't cleaned up its own act with an integrated form system that allows public service providers to provide service and to do so expeditiously. The state's needs trump the clinicians' needs and, therefore, the consumers' needs and I think CFAC should make an issue of that. If CFAC won't do that or if CFAC's concerns are ignored, then we don't need CFAC.	Thank you for recognizing major challenges in achieving system reform. Standardization is intended to address such a complex problem. We are all interested in paperwork reduction and streamlining the process.
	Judy Dempsey, family member, Albemarle CFAC, SCFAC, family member, Kitty Hawk	Streamlining standardization process	Chapter 3, objective on standardization	Achieving more integrated and standardized processes and procedures which allow for creativity, flexibility and possible innovation with accountability is extremely important as long as it doesn't complicate and lengthen the reporting process which is already burdensome and interfering with the delivery of service.	Thank you for recognizing major challenges in achieving system reform. Standardization is intended to address such a complex problem. We are all interested in paperwork reduction and streamlining the process.

Objective: Integrated & standardized processes and procedures

	From Whom?	Subject	Refers to Specific Text	Comments/Recommendations	Division Response:
	Holly Riddle, NCCDD	Various text changes in actions steps, milestones and other areas for standardization objective	Chapter 3, objective on standardization, pages 21, 23-25	Standardized Processes/Procedures-Action steps and milestones are ambitious. p. 21, par. 2: NCCDD supports DMH's assertion regarding quality: "every level of the system is accountable for the success for failure of the system." Quality is everybody's business. p. 21, par.2: Suggest you add this language, italicized: Provided the appropriate information and supports, "consumers must be accountable for their individual needs and standing up for their rights."	Change made.
				p. 21, par. 3: CMS's quality management system additionally requires that states provide a description of the roles and responsibilities of the parties involved in measuring performance and making improvements and, notably, includes among the parties to be involved waiver participants and advocates. This is a point worth making in the plan.	See chapter 4 in State Plan 2005 that outlines the details of the Quality Management Plan, including roles and responsibilities.
				p.23, Action Step 1: The NCCDD commends the DMH/DD/SAS for including in its action step a milestone re: assisting State and local Consumer and Family Advisory Committees (CFACs) in reviewing data and recommending responses.	Your comments will be given serious consideration as we develop the detailed implementation plan related to this objective.
				p.24, Action Step 4: replace "care" with "services" in last milestone	
				p.24, Action Step 6: Note that "performance measures" may vary among disability populations.	

Objective: Integrated & standardized processes and procedures

	From Whom?	Subject	Refers to Specific Text	Comments/Recommendations	Division Response:
	Holly Riddle, NCCDD, Continued	Various text changes in actions steps, milestones and other areas for standardization objective	Chapter 3, objective on standardization, pages 21, 23-25	p.24: Note: performance measures should be national, standardized measures. Implementation processes should minimize burden on provider agencies, or reimburse for their efforts. p. 24, Action Step 7: Include the CCNC (Community Care Network of North Carolina) in planning for sharing data and consumer- specific information p.25, Action Step 8: Consider adding an additional Milestone which focuses on the dissemination of the information mentioned in Milestone 1 to providers, consumers, family members and other stakeholders.	Your comments will be given serious consideration as we develop the detailed implementation plan related to this objective.
	Sally Cameron, NC Psychological Association	General comments on promoting consistency for standardization	Chapter 3, objective on standardization	While the goal of increasing consistency state-wide has many benefits, this goal cannot be accomplished by a change in rules alone. Significant variability exists with respect to state services funding per LME, local services funding per LME, local resources, community capacity, technology infrastructure, local planning and design and other factors. Plans for promoting consistency must take these factors into account. This goal should be accomplished in a manner that encourages statewide consistency without discouraging or punishing innovation and quality. LMEs and providers whose practices promote a higher standard of care, improved access to evidence-based practices, more timely payment of providers, and other laudable goals should be supported through exemptions, waivers or pilot recognition if changes in rules have an adverse impact on their practices.	Thank you for recognizing major challenges in achieving system reform. Your comments will be given serious consideration as we develop the detailed implementation plan related to this objective.

Objective: Integrated & standardized processes and procedures

	From Whom?	Subject	Refers to Specific Text	Comments/Recommendations	Division Response:
	Sally Cameron, NC Psychological Association	General comments on promoting consistency for standardization	Chapter 3, objective on standardization, page 21	"Inconsistency in the quality of providers" can be improved not just by increasing accountability, but through increasing the authority of LMEs with regard to provider enrollment and overall management of the quality of the provider network. increased technical assistance to LMEs and providers, and availability of information to all parties are essential. Additional state-level effort is needed to support workforce development.	Your comments will be given serious consideration as we develop the detailed implementation plan related to this objective, as well as Action Step 4 of the objective related to the provider system.

Objective: Consumer outcomes related to Housing

	From Whom?	Subject	Refers to Specific Text	Comments/Recommendations	Division Response:
	Dave Richards, External Advisory Team	Measurement	p. 39, table 3, housing row	We could focus on increasing the number of housing units in total, rather than by disability.	Your comments will be given serious consideration as we develop the detailed implementation plan related to this objective.
		Types of Housing		Need to stress that services and supports must be tied to access of some housing units.	
	Martha Brock, PAIMI Advisory Council Coordinator	Increasing awareness about housing for consumers	Chapter 3, objective 4 housing, action step 1, page 28	While the Objective and Action Steps on Housing are commendable, it struck me that the last action step, "convene training, presentations or workshops for consumers as well as family members to increase awareness about housing" is last in order of implementation date.	The timing of this Action Step as with many others is dependent on both the limitations of staffing resources and a necessary sequencing of tasks.
	Debra Dihoff, NAMI	Assessing the housing need	Chapter 3, objective on housing	That one of the five main goals is Housing is a laudable element of the plan. However, a strategy clearly needs to be included to know how many people need housing (more than just the special needs groups within the disability population) and how many received housing as a result of new initiatives.	Your comments will be given serious consideration as we develop the detailed implementation plan related to this objective.
	Judy Dempsey, family member, Albemarle CFAC, SCFAC, family member, Kitty Hawk	General comment	Chapter 3, objective on housing, page 28	"…providers responsible for the person-centered planning need to be able to recognize when a consumer needs assistance with getting or maintaining housing," possibly needs to be in bold in order to stress its importance. As does, "The performance domains that are related to this objective include individualizing planning and supports access to service, promotion of best practices and consumer focused outcomes."	Your comments will be given serious consideration as we develop the detailed implementation plan related to this objective.
	Linda Harrington, Director, Division of Vocational Rehabilitation	Importance of securing housing for successful employment initiatives	Chapter 3, objective on housing	It was also good to note that consumer housing would be listed as one of the five strategic objectives. Without satisfactory housing, successful treatment and employment outcomes cannot be obtained and maintained.	Your comments will be given serious consideration as we develop the detailed implementation plan related to this objective.
	Holly Riddle, NCCDD	Various text and comments changes on	Chapter, objective on housing, page 27-30	You will find much supporting information for this section in the TAC's updated report, "Priced Out", on the TAC website at: <http://www.tacinc.org/index0.htm.>	Your comments will be given serious consideration as we develop the detailed implementation plan related to this objective.

Objective: Consumer outcomes related to Housing

	From Whom?	Subject	Refers to Specific Text	Comments/Recommendations	Division Response:
		housing objective		Add "accessible" to "safe, decent, affordable housing" in introductory text and in outcomes for consumers. It is included in the system performance measures. The availability of home modifications that promote independence and safety in one's home is key if people with DD are to feel safe in their home and neighborhood.	Change made.
				NCCDD would encourage addition of a consumer outcome, consistent with "Money Follows the Person," re: increased percent of consumers who receive supports in a home that they lease or own. We would also encourage efforts to increase the number of individuals living in homes with 1-3 unrelated persons.	Your comments will be given serious consideration as we develop the detailed implementation plan related to this objective.
				p. 28, Action Step 1: Consider editing the Action Step to read, "…role that stable housing plays in treatment, recovery and/or full inclusion in the community." p. 28, Action Step 1, Bullet 4: Consider editing the Action Step to read, "…increase awareness about housing options and means for accessing these options." p. 28, Action Step 2, Bullet 1: Please note that "physically disabled" is not People First language. p. 29, Action Step 3, Bullet 1: Consider adding "Individual Development Accounts" along with "tax credit units". p. 30, Consumer Outcome, Bullet 1: Consider editing text to reflect "safe, stable and accessible homes in the community."	Changes or edits made.

Objective: Consumer outcomes related to education & employment

	From Whom?	Subject	Refers to Specific Text	Comments/Recommendations	Division Response:
	Tom Savidge, External Advisory Team	Consumers with SA		Persons with substance abuse often have difficulties getting jobs due to past criminal records, so a different strategy is needed. Collaboration and mediation may be needed within DHHS or legislative action may be needed for unique cases.	Thank you for recognizing major challenges in achieving system reform.
	Martha Brock, PAIMI Advisory Council Coordinator	Timeliness of training consumers and family members	Chapter 3, objective 5 on education and employment, action step 1 & 2, page 32	Under the Objective for Education and Employment, I question the timing and priority for providing "training workshops and/or presentations for consumers and also family members…" under Action Step 1 (page 32). The same question is raised in Action Step 2 for Education and Employment. Why wait until 6/30/09 to implement peer directed and delivered services? The objective is sound, but I question the amount of time to implement. Both of these items should be of higher priority.	The timing of this Action Step as with many others is dependent on both the limitations of staffing resources and a necessary sequencing of tasks.
	Betsy MacMichael, First in Families	Word choice	Chapter 3, objective on education and employment, page 27-36	P.31 (actually 27)- Serve**s** not Serve P.32- Action Step 1: ...treatment and recovery for people with mental illness. If you are trying to be broader here, then change the wording because as we have expressed many times, people with DD do not recover... P.34 (actually page 30)- Bullet 3 reads funny.. how about: "...increased number of formerly homeless individuals with disabilities now living in stable housing" If you reword this, cut/paste to Table 3, p.43 as well... P.36 AS1 (action step 1) - play not plays	Change or edits made.

Objective: Consumer outcomes related to education & employment

	From Whom?	Subject	Refers to Specific Text	Comments/Recommendations	Division Response:
	Joseph Kilsheimer, Durham CFAC	Overall comment on consumer complaints	Chapter 3, objective on education and employment, page 32	All reviewers thought the plan was overly "wordy" almost to the point that it was unwieldy as an action plan document; for example each subject area listed as the # 1 priority for June 30, 2008,"A Review of Consume Complaints ON PAGE 32. This would indicate few or no changes would occur for at least a year. One of our members felt that there are already some discerned patterns of complaints. We would suggest wording that the Division make a quick review early on to capture the top 3,5,or 10. This would not need to be a tedious process and to move to act on those most glaring quickly.	The timing of this Action Step as with many others is dependent on both the limitations of staffing resources and a necessary sequencing of tasks. Your comments will be given serious consideration as we develop the detailed implementation plan related to this objective.
	Joseph Kilsheimer, Durham CFAC	Reference to recovery for individuals with developmental disabilities	Chapter 3, objective on education and employment	Any reference to Recovery applied to the Developmentally Disabled Population is irrelevant to this group of consumers. Recovery is a medical term, and folks with DD do not recover, We would suggest that the division come up with other wording. Most of us are looking for a way to optimize, making the most of ones life in difficult circumstances.	Change made.
		Role of providers in education and employment objective		P.31 " Every provider must discover the importance of Education or Employment for each consumer they serve." This statement is too general. There is a need for greater specificity as how to achieve such lofty objectives. Generally page 31 seems to be an impossibly wordy attempt to say that all of us, (the very able and the less able), need to have something to do with our lives, something we enjoy. It is incumbent on the people who serve the needs of the MH/SA/DD population to strive to help our consumers to find that something.	Your comments will be given serious consideration as we develop the detailed implementation plan related to this objective.

Objective: Consumer outcomes related to education & employment

	From Whom?	Subject	Refers to Specific Text	Comments/Recommendations	Division Response:
	Joseph Kilsheimer, Durham CFAC	Establishment of resources to support the education and employment of consumers	Chapter 3, objective on education and employment	Page 32 While it is important to utilize resources in the community such as the public schools, community colleges, local colleges/universities and Vocational Rehabilitation services to support consumers' access to job skills training and actual employment opportunities in the three populations, MI, DD, SA need consistent and available Case Managers, Job Coaches and other personnel to make Supported Employment a reality. This "supportive village" must be in place before meaningful educational and employment opportunities that will fully engage consumers.	Your comments will be given serious consideration as we develop the detailed implementation plan related to this objective.
		Variety of employment opportunities for consumers		Page 33 Action Step 3: Expand and Enhance joint efforts within the Division of Vocational Rehabilitation. It is hoped that the Division can offer consumers who are at a higher level of functioning, job training and eventual employment in substantive work environments and not just simple repetitive make work. In the past, the Division has had limited workplace opportunities for adult consumers with higher skills levels. These consumers became discouraged with prospects for meaningful and self-fulfilling employment.	
		Overall comment on education and employment		Finally on reading Action Step on Page 33, we had thought the document addressed a huge aspect of this thorny issue; namely the built in disincentives for the various populations to seek out employment and the havoc this can play for those who have achieved eligibility for SSI of SSDI. On further review this action step lists merely the addresses publicizing the status quo, listing the way the system is structured. Somehow, some way we all need to examine the system as it currently exists and work to change it so as not to thwart the initiative of people who want to work to support themselves and are striving to better their lot in life.	Agreed. Your comments will be given serious consideration as we develop the detailed implementation plan related to this objective.

Objective: Consumer outcomes related to education & employment

	From Whom?	Subject	Refers to Specific Text	Comments/Recommendations	Division Response:
	Joseph Kilsheimer, Durham CFAC	Use of MH Trust Funds	Chapter 3, objective on education and employment, page 35	Page 35 In discussion some of our members are troubled by the dependency on monies from The Mental Health Trust Fund as stated throughout this document, Such monies have been considered to be a "rainy day fund", for mental health needs. At the rate of spending from this Fund as outlined in SSP 2007-2010, precious little for a "rainy day" will remain at the end of the three years.	Thank you for your comments. The Mental Health Trust Fund will be used in accordance with requirements of the General Assembly.
	Judy Dempsey, family member, Albemarle CFAC, SCFAC	Training and collaboration with Division of Vocational Rehabilitation	Chapter 3, objective on education and employment	Not every consumer can benefit from education and employment (extremely low functioning retarded or severely disabled consumers), but those that can should have the opportunity and support. Those that can only maintain their current level of functioning should be given the support necessary to maintain, and not regress to, a lower level of functioning. Providing the necessary training, technical assistance and funding for providers and LMEs is crucial as is cooperation with the Division of Vocational Rehabilitation for training and employment opportunities.	Agreed. Your comments will be given serious consideration as we develop the detailed implementation plan related to this objective.
		Transitioning to adult workforce		In “Increased percentage of educational and job placement for youth (to age 21),” those youth need help transitioning to placement in the adult workforce.	

Objective: Consumer outcomes related to education & employment

	From Whom?	Subject	Refers to Specific Text	Comments/Recommendations	Division Response:
	Linda Harrington, Director, Division of Vocational Rehabilitation	Employment documentation in person-centered plans, expansion of employment services and tracking employment services and placement	Chapter 3, objective on education and employment	I was pleased to see that the entire document was so outcome-oriented. I commend your agency for giving such an emphasis to supported employment and to employment in general. I'm also glad to see that the Division will be expecting providers to address employment and education issues with each consumer as the person-centered plan is being developed. It was encouraging as well to see that our recently developed Interagency Memorandum of Agreement was mentioned and that customer service staff within the LMEs will be disseminating information to various groups regarding the benefits of employment. It was stated within the plan that supported employment and job placement services will be expanded. I assume that any job placement services provided would be within the context of ACT team services - provided by the team vocational specialist - because, otherwise, there may be a duplication of services that are typically provided by our Division. I also noted that employment outcomes will be tracked and that more employment opportunities within the public mental health system will be made available to consumers as will the emphasis on obtaining consumer input - including input into crisis services planning.	Thank you for recognizing major challenges in achieving system reform. Your comments will be given serious consideration as we develop the detailed implementation plan related to this objective.

Objective: Consumer outcomes related to education & employment

	From Whom?	Subject	Refers to Specific Text	Comments/Recommendations	Division Response:
	Holly Riddle, NCCDD	Text and various recommended changes	Chapter 3, objective on education and employment, pages 31-34	Education and Employment-Citing, at par.3, p.31, to the recommendations in these two areas of "A Charge We Have to Keep," from the President's Committee for People with Intellectual Disabilities" could strengthen your text in this section. Cf. http://www.acf.hhs.gov/programs/pcpid/2004_rpt_pres/2004_rpt_pg7.html NCCDD would recommend that the narrative in this section include asset development, per the President's Committee report, cited above.	Change made.
				Consider as consumer outcomes: Increased percent of individuals age 18 and over who are supported in community integrated employment compared to the total number of adults who receive day services; also, the percent of people earning at or above the state minimum wage.	Your comments will be given serious consideration as we develop the detailed implementation plan related to this objective.
				p. 31, Paragraph 1: Consider replacing the "or" statements with "and" statements when discussing "education, employment or meaningful daily life activities". The use of the word "or" implies that these are mutually exclusive.	Change made.
				p. 32, Paragraph 1: Consider replacing "community colleges" with "institutions of higher learning" and broadening the list of partners to include employers and typical employment services. p.32 Action Step 2: consider expanding employment supports available through the state Medicaid plan for all disability groups.	Your comments will be given serious consideration as we develop the detailed implementation plan related to this objective.
	Holly Riddle, NCCDD	Text and various recommended changes	Chapter 3, objective on education and employment,	p. 32, Action Step 1, Bullet 2: Unclear	Edits made.

Objective: Consumer outcomes related to education & employment

	From Whom?	Subject	Refers to Specific Text	Comments/Recommendations	Division Response:
			pages 31-34	p. 33, Action Step 4, Bullet 1: Consider coordinating efforts with other agencies that may already be engaged in these activities (i.e. NC DVRS – BPAO/WIPA program) p. 34, Consumer Outcomes, Bullet 3: Consider deleting reference to DD population.	Your comments will be given serious consideration as we develop the detailed implementation plan related to this objective.
				p. 34, System Performance, Bullets 1 and 2: Consider replacing "maintenance of entitlements and other benefits while employed" with "public benefit options while employed."	Edits made.
	Linda Harrington, Director, Division of Vocational Rehabilitation	General comments about plan	Chapter 1	In closing, I want to emphasize that the Division of Vocational Rehabilitation Services is clearly your partner in this undertaking. We intend to work with your Division to assure that all consumers with the desire to work have the opportunity to achieve their employment goals, whether the goal is traditional employment, supported employment, or self-employment.	We welcome your partnership in this effort.

Chapter 4. Measures of Results

	From Whom?	Subject	Refers to Specific Text	Comments/Recommendations	Division Response:
	Judy Dempsey, family member, Albemarle CFAC, SCFAC	General comment on tables	Chapter 4, pages 36 and 38; Chapter 5, pages 43	Tables 2 and 3 (Chapter 4) & Table 4 (Chapter 5) are very helpful	Thank you for your comments.
	LOC, Co-chairs Sen. Martin Nesbitt and Rep. Verla Insko	General comments on plan	Chapter 4	As requested, there is an emphasis on outcome and performance measures. We do not, however, find any baseline or benchmark against which those measures will be compared. We would strongly request that the approved State Plan specify where we are starting. Without that, it is impossible to measure any progress.	Where prior years' data are available, the Division will calculate and publish baselines during the first quarter of SFY 2008. Where not available, baselines will be developed during the first year of data collection. Please see the Division's quality reports developed in SFY 07 in response to legislation, including the Community Systems Progress Indicators Report and the Semi-Annual System Performance Report. These reports can be found on the Division's web site: http://www.ncdhhs.gov/mhddsas/statspublications/reports/index.htm.

Chapter 5. Implementation Structure and Process & Proposed Use of Mental Health Trust Funds

	From Whom?	Subject	Refers to Specific Text	Comments/Recommendations	Division Response:
	LOC, Co-chairs Sen. Martin Nesbitt and Rep. Verla Insko	General comments on plan	Chapter 5	The draft Plan relies heavily on future planning, the development of guidance, and the identification of measures. We look forward to reviewing the actual plan, guidance, and measures as they are produced. Without these, it is difficult to determine whether the Department will actually achieve those ends. Similarly, the end of the draft Plan notes that the Division will develop more detailed plans for each objective after the State Plan is approved. Again, we look forward to seeing that detail and specifically request that those plans be submitted to the LOC as they are developed.	The planning process, completed thus far in a short period of time, has focused on identifying essential objectives and actions to be taken during the next 3 years. Planning continues with specifying and sequencing detailed tasks to fully implement and accomplish the action items and objectives.
				We are concerned that the draft Plan does not identify additional resources that may be needed to implement Reform. We are also disappointed that there continues to be no plan or recommendations for the phased-in elimination of State funding disparities among LMEs. There continues to be a statutory obligation upon the Department to provide for this in the State Plan. See G.S. 122C-102(b)(12).	The final plan has been updated to respond more directly to this request.
	Martha Brock, PAIMI Advisory Council Coordinator	Involvement of consumers in planning changes	Chapter 5, implementation	One of the weaknesses of the implementation of the previous state plans has been a lack of involvement of primary and secondary consumers in the planning of the changes as they have been implemented over the past several years.	Your comments will be given serious consideration as we develop the detailed implementation plan related to this objective.
	Thea Dockery	Use of MH Trust Fund	Chapter 5, strategic use of MH Trust Funds	The allocation of money from the mental health trust fund should be given to appropriate officers at the beginning of the fiscal year, after the master budget has been completed and approved.	We have recently received specific directions from the General Assembly regarding the Mental Health Trust Fund.

Chapter 5. Implementation Structure and Process & Proposed Use of Mental Health Trust Funds

	From Whom?	Subject	Refers to Specific Text	Comments/Recommendations	Division Response:
	Debra Dihoff, NAMI	Use of MH Trust Fund	Chapter 5, strategic use of MH Trust Funds, page 43	The use of trust fund dollars in innovative ways is a strong element of the plan.	We have recently received specific directions from the General Assembly regarding the Mental Health Trust Fund.
		Funding MH/DD/SAS transformation	Chapter 5	The plan needs to address head-on the need to move our funding up from a 43rd per capita level in this state. Clearly there is a correlation between the state of reform, the problems of access, and insufficient money.	Your comments will be given serious consideration as we develop the detailed implementation plan related to this objective.
	Holly Riddle, NCCDD	Waiting lists, Division's organizational structure	Chapter 5, implementation, page 41-43	NCCDD commends the statement at p. 41 that "strategies of leadership, organizational frameworks and consumer input are valued as non-negotiable." At p. 42, we welcome the DMH/DD/SAS's stated commitment to "creating and designing new ways to participate in different stakeholder groups, by providing leadership forums," etc. p. 43: NCCDD encourages the DMH/DD/SAS to resume maintenance of a viable, waiting list for services. The NCCDD recommends that the DMH/DD/SAS review its organizational structure as it takes on Plan implementation over the next three years. The Division's cross-disability, functional structure appears to have resulted in both a loss of senior DD expertise and difficulties accessing available DD expertise in the DMH/DD/SAS. As a result, it has been challenging to advance a progressive policy agenda for people with developmental disabilities and their families.	Your comments will be given serious consideration as we develop the detailed implementation plan related to this objective.
	LOC, Co-chairs Sen. Martin Nesbitt and Rep. Verla Insko	Use of MH Trust Fund	Chapter 5, use of MH Trust Funds, page 43	The draft Plan offers a list of ways that the Mental Health Trust Fund could be used to support the State Plan objectives. However, that list does not prioritize those uses. We would urge the Department to determine and identify those priorities.	We have recently received specific directions from the General Assembly regarding the Mental Health Trust Fund.

Chapter 6. Communications Plan

	From Whom?	Subject	Refers to Specific Text	Comments/Recommendations	Division Response:
	Martha Brock, PAIMI Advisory Council Coordinator	Communication needs for non-internet using consumers and families	Chapter 6, Communications Plan	Increased awareness should come first and foremost in all action steps. To achieve this, more emphasis on communication with the public and with services users is necessary. And please remember those who are not Internet savvy, when planning communication practices for consumers and family members!	Your comments will be given serious consideration as we develop the detailed implementation plan related to this objective. A customer-friendly means will be established to respond to questions about the implementation of the strategic plan.
	Judy Dempsey, family member, Albemarle CFAC, SCFAC	Expanding communication list to include all endorsed providers	Chapter 6, Communications Plan	Communicating the plan needs not only to go to those listed but all endorsed providers who should be required to communicate the appropriate sections to consumers and their families. All Town Hall meetings should be published in local papers, radio and TV stations. LMEs should be required to inform consumers and their families of the time, place and purpose of the meeting.	Your comments will be given serious consideration as we develop the detailed implementation plan related to this objective.